Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRACKENRIDGE HOSPITAL
P O BOX 600124
DALLAS TX 75360

Carrier's Austin Representative Box
Box 01

MFDR Date Received
MARCH 31, 2006

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-06-5029-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As set forth under Rule 134.401 (4)(C), 'Pharmaceuticals greater than $250.00 charged per dose shall be reimbursed at cost to the hospital plus 10%'. Please note that this patient suffered a snake bite and the drugs required are unusually expensive to the hospital and as such, should be reimbursed according to this Rule."

Amount in Dispute: $20,509.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 20, 2006: "…The bill has been re-reviewed and our position remains the same. Our rationale is as follows: The provider has requested reimbursement at 75% of billed charges because it is a trauma admit. Liberty Mutual's position is that it is not a true trauma admission. The principle diagnosis code is IC9 989.5 and it does not fall the code rate that supports trauma reimbursement. However, it is noted that 1 day of inpatient say was a step down-ICU bed. Therefore additional reimbursement was made for ICU per diem 1 day $1,560.00 – 10% PPO discount. Interest was paid at 11.41…**2 days at the TX FS Medical per diem = 1740.40**…**1 day @ the TX FS ICU rate $1,560.00**…**Pharmacy carve out anti-venim 2 x $1870.07 (cost of drug) = $375.71 (10%) = $4133.95 allowed for pharmacy carve out. Total TX FS allowable: $6743.95 x 90% = $6069.56**…**Total payment made per PPO: $6069.56**…Liberty Mutual does not believe that Brackenridge Hospital is due any further reimbursement…"

Response Submitted by: Liberty Mutual Insurance Co., 2875 Browns Bridge Road, Gainesville, GA 30504

Requestor's Supplemental Position Summary Dated October 27, 2011: "Carrier has previously responded to this dispute on April 26, 2006. Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive Ogden & Latson, P. O. Drawer, 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 7, 2005 Through April 10, 2005	Inpatient Hospital Services-Pharmaceuticals Only	$20,509.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F – (Z560) – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE. (Z560)
- C – (P303) – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
- PA – FIRST HEALTH NETWORK

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code C – (P303) "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(1) states "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401 (c)(2)(A) states "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical and surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401 (c)(3)(A)(i and ii) states "Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.

3. Review of the submitted documentation finds that the services provided were medical; therefore the standard per diem amount of $870.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The medical per diem rate of $870.00 multiplied by the length of stay of two days results in an allowable amount of $1,740.00.

   28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed 26 units of Crotalid Immfabul for a total charge of $24,229.75. The

requestor did not submit documentation to support what the cost to the hospital was for Crotalid Immfabul. For that reason, reimbursement for this item cannot be recommended.

The division concludes that the total allowable for this admission is $1,740.00 per diem. The respondent issued payment in the amount of $3,730.56. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 1, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.